TRICARE MANAGEMENT ACTIVITY

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Operational Report for January 1, 2001 through December 31, 2001

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Program Integrity

The TRICARE Management Activity (TMA) Program Integrity (PI) Office is the centralized administrative hub for surveillance of fraud and abuse activities worldwide involving purchased care for beneficiaries in the Military Healthcare System. PI is responsible for developing policies and procedures regarding prevention, detection, investigation and control of TRICARE fraud, waste and program abuse, monitoring contractor program integrity activities, coordinating with DoD and external investigative agencies and initiating administrative remedies as required. The TMA PI Office is located in the Acquisition Management and Support Directorate.

TMA PI provides technical assistance and guidance to the DoD-Office of the Inspector General (IG) for Investigations and to U.S. Attorneys in developing cases for prosecution, to include expert witness testimony. Through a Memorandum of Understanding, Program Integrity refers its provider fraud cases to the Defense Criminal Investigative Service. PI coordinates investigations with offices and agencies of the Department of Justice, DoD-IG, various Military Departments and federal, state and local agencies. PI administers the administrative procedures related to provider exclusions, suspensions, terminations and reinstatements. PI is the principal point of contact for research, analysis, and coordination of DoD "Hotline" complaints.

A member of the National Healthcare Anti-Fraud Association (NHCAA), TMA PI shares fraudulent billing schemes with other private and public healthcare plans. December 2001 marked the first time in its 16-year history that the NHCAA selected TMA PI as the public sector liaison representative to the Executive Committee. TMA PI is also the TRICARE Liaison Member of the Department of Justice Healthcare Fraud Working Group. TMA PI works with the FBI, state investigative agencies, and the numerous healthcare fraud task forces established throughout the United States. These healthcare fraud task forces have representatives from the entire spectrum of government and private healthcare plans.

During 2001, TMA PI opened 311 new cases, responded to 532 requests for assistance, evaluated 141 new *qui tam* cases and closed 387 cases. Qui Tam is a provision of the Federal Civil False Claims Act that allows private citizens to file a lawsuit in the name of the U.S. Government charging fraud by government contractors and others who receive or use government funds and share in any money received. This unique law facilitates the effective identification and prosecution of government procurement and program fraud and the recovery of revenue lost as a result of the fraud.

TRICARE's Operation Fraud Watch

In September 1999, TMA PI launched TRICARE's Operation Fraud at a fraud training conference held in Myrtle Beach, South Carolina. The Myrtle Beach site was chosen to promote attendance at the conference by TRICARE's largest claim processor, Palmetto Government Benefits Administrators (PGBA) located in Florence and Surfside Beach, South Carolina. Representatives attended from most of TRICARE's prime contractors including Anthem Alliance Health Insurance Company; Foundation Health Federal Services, Inc.; Humana Military Healthcare Services; Sierra Military Health Services; and United Concordia Company, Inc.; as well as the claims processing subcontractors, PGBA and Wisconsin Physicians Service.

The initial conference was a huge success and attended by various government agencies that work together to combat fraud. As a result of this conference, an agreement was made between TMA and the Defense Criminal Investigative Service (DCIS) to alternate sponsoring the conference.

The Executive Director of TRICARE Management Activity attended the press conference announcing the Columbia Hospital settlement in December 2000. The Attorney General of the United States publicly recognized and praised TMA's contribution to the investigation and settlement which resulted in a return to TRICARE of $7.4 million.

Training and Educational Efforts

On January 1, 2001, TMA PI launched the TRICARE fraud and abuse web page at **http://www.tricare.osd.mil/fraud.** The web site offers visitors a section on fraud and abuse news releases, frequently asked questions, access to the TRICARE Sanctioned Provider List, as well as a link to the Department of Health and Human Services Consolidated Provider Sanction List, and fraud and abuse links. Beneficiaries and providers may also report allegations of fraud through a direct link to the managed care support contractor's program integrity fraud unit. Between March 27, 2001, and January 1, 2002, 4,880 individuals contacted the web site.

In August 2001, TMA PI hosted the third TRICARE Healthcare Fraud Conference in San Diego, California. The conference consisted of two and one half-days of instruction. Presenters from the Department of Justice, Defense Criminal Investigation Service, the Federal Bureau of Investigation, TMA's Program Integrity Office, and others provided a comprehensive training course full of healthcare fraud information. The audience consisted of investigators, attorneys, and industry experts. Plans to hold the next TRICARE Healthcare Fraud Conference are already underway. Tentatively, the conference will be held in San Antonio, Texas, in April 2003.

In April 2002, the recipient of the Contractor Performance of the Year 2001 Award for its work in detecting fraud and abuse, Humana Military Health Services, is hosting a Contractor Information Sharing Roundtable Session. The participants will include TMA's Program Integrity Office, personnel from the primary contractors' program integrity units, personnel from the claim processing subcontractors' program integrity units, and others by invitation. The roundtable will focus on brainstorming sessions designed to increase productivity and teamwork. There will also be training sessions conducted by an Assistant United States Attorney and Special Agents from Defense Criminal Investigative Service who are assigned to the region where Humana is located.

In conjunction with the August 2001 Fraud Conference, the Program Integrity Office conducted the first-ever Beneficiary Fraud Awareness Forum. Guest speakers included Congresswoman Susan Davis and Major General Jan C. Huly, Commander of the Marine Corps Recruiting Depot in San Diego. Three 2-hour courses were held in San Diego, California, for beneficiaries to learn about the TRICARE program. The information shared with the beneficiaries included topics such as: TRICARE for life (the opportunity for eligible members over 65 to regain TRICARE eligibility as a second payer to Medicare), fraud and abuse training, resources available at TRICARE Service Centers, and resources available at the Lead Agent's Office.

TMA PI takes an active role in training and educational efforts related to fraud and abuse. In 2001, the Office was directly responsible for providing fraud and abuse training and computer and technical program support to more than 3,100 people. Organizations that attended the varied training programs include the Department of Army, Department of Air Force, Department of Navy, United States Coast Guard, Defense Criminal Investigative Service, Department of Justice, Federal Bureau of Investigation, Department of Health and Human Services, and organizations outside of the federal government. Speakers from the Program Integrity Office provided training at the following courses: the TRICARE Basic and Advanced Student Course; the Federal Health Care Acquisition Conference,

multiple Lead Agent conferences; the orientation for the Lead Agent Medical Directors; training for Defense Criminal Investigative Service; and the TRICARE National Conference.

Impact of Fraud on the Quality of Care

Although a relatively small percentage of providers commit healthcare fraud, the dollar impact is significant. It is estimated to impact from 3 to 10 percent of all healthcare expenditures. The term "providers" includes virtually all types of healthcare services: hospitals, ambulance companies, home nursing programs, durable medical equipment vendors, medical suppliers, pharmacies, physicians, mental health counselors, podiatrists, physical therapists, etc.

Fraud can adversely impact quality of care and result in patient harm when "profit" is put ahead of what may be in the best interests of the patient. The following vignettes illustrate this point:

Lab Sink Test

The "lab sink test" scenario occurs when normal results are reported on untested lab specimens that are poured down the sink. With disregard for the welfare of the patients involved, the lab keeps administrative costs low and maximizes profits by engaging in this scheme. Patients on the other hand may experience delays in being properly diagnosed, which could result in permanent impairment or even death. The "lab sink test" scenario impacts the beneficiaries and subscribers of both private and public plans.

Adulterated Medications or Biologicals

During 2001, authorities discovered a pharmacist with pharmacies in Kansas and Missouri who diluted cancer chemotherapy drugs. TMA PI immediately explored the possibility of TMA beneficiaries being affected by this fraudulent practice. Although no TRICARE patients received these adulterated chemotherapeutic agents, TMA PI alerted TRICARE Service Centers at Fort Riley, Fort Leavenworth, and Whiteman AFB to prepare for beneficiary questions.

Diluted Immunizations

In a California case , TRICARE patients received diluted well-baby immunizations. The pediatric corporation acknowledged that they had diluted immunizations for a period of approximately two and one-half years and that the dilutions were done with the specific intent to defraud patients and the insurance providers. Until this admission, scores of patients and their families doubted these allegations. Of the nearly 4000 patients identified, only 400 were actually tested to determine their level of immunity. Of these 400, approximately 66 percent were found to be unprotected from Hepatitis B. TMA PI and the MCSCs assisted local authorities in notifying military families of the need to retest those children who had been vaccinated by this provider to verify adequate levels of immunization.

Whether it is the indiscriminate prescribing of addictive drugs, diluting chemotherapy or well-baby vaccine injections, patient notification is an essential aspect of a corrective action for a healthcare fraud scheme.

The above scenarios exemplify the two priorities of TMA PI – identification of potential patient harm cases (regardless of the dollar amount) and non-patient harm cases involving large dollar losses. This identification process facilitates TMA to direct its limited resources toward ensuring that military families receive quality healthcare in a cost-effective manner. By continuing to share information with other government agencies and the private sector, healthcare fraud can be brought under control, thus contributing to the ability to provide affordable, quality healthcare to all citizens of the United States.

TRICARE's Clinical Quality Forum

Because of the recognized relationship between quality of care and health care fraud, TMA PI is a member of the TRICARE Clinical Quality Forum, the OASD(HA)/TMA Committee with oversight responsibility for clinical quality assessment programs. The Forum's primary responsibility is to monitor and assess the quality of health care provided to Department of Defense beneficiaries and to report findings in an annual report to the Assistant Secretary of Defense (Health Affairs) and Congress. The Forum is an important vehicle for providing recommendations to senior leadership pertaining to the future clinical quality initiatives and oversight programs. The Forum contributes to ensuring quality and cost-effective care for military families whether the care is received in the military health care system or through the purchased care side of TRICARE.

TRICARE's National Database

To respond to those who investigate or prosecute fraudulent practices, TMA DI uses a TRICARE database, the Health Care Service Record (HCSR) which maintains information on covered beneficiaries and health care providers. The HCSR facilitates the investigation of allegations of fraud and abuse through analysis of a suspected provider's billing patterns and an assessment of the cost for use by the Department of Justice in its settlement negotiations.

The HCSR is derived from data forwarded by TRICARE MCSCs in a specific format that is run against a specific set of edits. Although the data requirement contributes to data integrity and the fiscal soundness of a single audit trail, the extensive information required places an administrative burden on the MCSCs. Therefore, with the implementation of the next generation of contracts, the TRICARE Encounter Data System (TED) will replace HCSRs. TED will be the new, streamlined, collection of purchased care data from the contractors that will be used to meet government requirements for health care information. Implementation of TED will comply with the requirements cited in the National Defense Authorization Act for Fiscal Year 2001 and will promote efficiencies and cost savings for the contractors and the government. TED will also improve TMA's ability to implement the Health Insurance Portability and Accountability Act of 1996 requirements, provide for more timely access to purchased care data, and capture critical fields such as the National Drug Code, Referring Physician, and National Provider ID.

Relationship with the Defense Criminal Investigative Service

In Fiscal Year 2001, TRICARE provided services for 8.2 million eligible beneficiaries worldwide. The healthcare budget for the Department of Defense is $18.1 billion. This includes the Military Treatment Facilities and the non-defense facilities. Federal health care programs working collaboratively were able to identify $145,380,671 in criminal cases and $830,155,023 in civil cases

for a grand total of $977,200,553 federal dollars in judgment. This compares to judgments of $528,171,896 for all federal programs for FY 2000. The federal programs include TRICARE, Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). Several vignettes follow that illustrate successful recovery efforts.

Lifescan ®- Faulty Glucose Monitoring Equipment

A *qui tam* suit against Lifescan, Inc.®, a blood glucose home monitoring device manufactured by Johnson and Johnson, resulted in a successful recovery effort. The relator alleged the senior management of Lifescan® and Johnson and Johnson were aware of faulty programming which lead to inaccurate blood glucose readings which are used to assess glucose control and to calculate insulin dosage. Inaccurate blood glucose readings can result in a diabetic emergency of profound hypoglycemia or diabetic ketoacidosis with life-threatening consequences. The Department of Justice negotiated a $30 million dollar settlement on behalf of all federal programs, including a $1.8 million dollar award to TRICARE.

Case Study: TAP Pharmaceuticals - Charging for Free Samples

Lupron® is a medication primarily used in the treatment of women diagnosed with endometriosis or uterine leiomyoma. Pharmaceutical companies regularly provided doctors with free samples of these medications to encourage them to prescribe the medication to their patients. Some of the physicians breached ethical duties and violated the law by charging patients for these free samples of Lupron. Through the use of TRICARE's national database, it was determined that TRICARE beneficiaries paid cost-shares for the "free samples." These "free samples," cost-shared by the government, resulted in an unnecessary expenditure of taxpayer dollars. The Department of Justice represented the interests of TMA in this matter, and judgment was returned for TAP Pharmaceuticals to pay $854 million in damages to all effected programs. TRICARE's recovery was $101,000 dollars.

Case Study: Valley Counseling - Services not Rendered

Everseley Haswell of Valley Counseling of Colorado pled guilty to two felony counts of Healthcare Fraud, one felony count of Conspiracy to Defraud with Respect to Claims and one felony count of Criminal Forfeiture. His wife, Karla Haswell, also of Valley Counseling of Colorado, pled guilty to one felony count of Healthcare Fraud, and one felony count of Conspiracy to Defraud with Respect to Claims. This culminated a six-year investigation of Valley Counseling. This billing fraud scam involved filing claims for services not provided and using an authorized provider's identification to submit claims for services that, when rendered, was done so by an unauthorized provider. Principals, Everseley and Karla Haswell were submitting false claims to TRICARE and Medicare for mental health counseling that was not being provided. TRICARE will recover approximately $498,339 dollars in damages. Mr. Haswell received a sentence of 21 months' imprisonment and three years released supervision. Karla Haswell received six months' home detention and five years' probation.

Fraud Recoveries

Thus far, TRICARE received judgements for $11.2 million dollars for fiscal year 2001. The dollars returned are shared with the managed care support contractors at the rate of approximately

20 percent of the dollars recovered, depending on the dates of care involved in the judgment and the terms of the contract. Another $1.6 million resulted from administrative recoupments. The remaining dollars are disbursed among the various branches of the Uniformed Services as TRICARE benefit dollars.

Case of the Year Award

The TRICARE case of the year award recognizes excellence in the detection and resolution of health care fraud. Award criteria include the development and referral of the case by a TRICARE contractor or fiscal intermediary, acceptance by DCIS and successful prosecution or settlement by Department of Justice. The Program Integrity Staff of Palmetto Government Benefits Administrators (PGBA), a member of the DCIS, and two Assistant United State Attorneys (AUSAs) from the Eastern District of Virginia received the 2001 TRICARE Case of the Year Award for handling of Consultants in Nutritional Services (CNS). A Health Care Benefits Advisor from the Oceana Medical Clinic at Oceana Naval Air Station, Virginia Beach, Virginia, received recognition for initiating the referral that resulted in the investigation.

CNS was providing nutritional counseling and weight loss management to its clients, neither of which are covered under TRICARE, Medicare or TRIGON. CNS claims circumvented the edits designed in the three programs to identify exclusions. The claims falsely depicted the provider of services and disguised the actual services provided.

Balance Billing and Violation of Participation Agreements

TMA Program Integrity is responsible for ensuring that non-participating providers comply with Public Law 102-396, section 9011, passed by Congress as part of the Department of Defense Appropriations Act for 1993. The text of this Public Law limits the billed charges to no more than 15 percent of the allowable rate.

Section 731 of the National Defense Authorization Act for Fiscal Year 1996, revised 10 U.S.C. 1079 (h), the statutory basis for limits on balance billing of TRICARE beneficiaries established in 32 CFR 199.14 (h)(1)(I)(D). Effective January 1, 1999, Section 731 extended the balance billing limit authority to non-institutional, non-professional providers such as pharmacies, independent laboratories, durable medical equipment and medical supply firms, ambulance companies, portable x-ray companies, and mammography suppliers.

This law specifies that non-participating providers are allowed to collect a maximum of 15% over the CHAMPUS Maximum Allowable Charge (CMAC) from a TRICARE beneficiary. It is considered fraud if participating providers (those marking “yes” to accept assignment on the claim form) attempt to collect from TRICARE beneficiaries amounts in excess of the TRICARE Maximum Allowable Charge (TMAC). If providers attempt to collect monies in excess of what they are entitled to collect, beneficiaries are instructed to notify the MCSCs. Currently the contractors have a success rate of over 95 percent in resolving these disputes. After an unsuccessful attempt by the contractor to resolve a case, the case is forwarded to TMA Program Integrity. Currently, the TMA PI has a 100 percent rate of success in the resolution of balance billing, violation of participation, hold-harmless process, waiver of liability and disputed diagnostic related group (DRG) cases

Occasionally, providers file a summons and issue a complaint prior to referral to the TMA Program Integrity Office. These providers are informed that federal law takes precedence over decisions made at the local or state level. TRICARE beneficiaries cannot be held liable for charges over 15% of CMAC or for any interest, costs, or attorney fees.

Between January 2001 and December 2001, TRICARE received 19 violations of participation agreement cases and 23 balance billing cases. TMA PI effectively intervened and prevented the erroneous payment of $9,542 to providers by beneficiaries. This kind of stewardship on the part of Program Integrity makes a positive difference to the family budget of affected families.

Balance Billing Vignette 1

> When an active-duty family tried to purchase a house, their credit report indicated an outstanding debt. The outstanding debt related to a balanced bill sent to the beneficiary and ultimately to a collection agency by an oral and maxillofacial surgery provider. The provider billed $3,000.00 for services for which the allowable charge was $1,579.94 and then billed the beneficiary for the difference despite educational letters from our contractor explaining the 115% limit. Following the Program Integrity Office intervention, the provider removed the beneficiary's name from collections and wrote off $1,438.06 that was being billed.

Balance Billing Vignette 2

> A beneficiary who paid $20 a month for seven years toward a bill of $4,144.75 contacted TMA's Program Integrity Office after learning of the "safety net" for military families who are wrongly billed. TMA PI discovered that the provider being paid had violated the participation agreement by collecting amounts in excess of the allowable charge. Program Integrity educated the physician who promptly offered not only to terminate the collection action but also to refund the amount already collected from the beneficiary, almost $1,500.00.

Contract Oversight and Compliance

To develop a more effective fraud and abuse detection, prevention, and referral program among each of the Managed Care Support Contractors (MCSCs), TMA PI expedited implementation of Chapter 14 of the Managed Care Support Contractor Operations Manual. The requirements outlined in Chapter 14 reflect the increased emphasis on healthcare fraud and abuse. Chapter 14 standardizes specific categories of actions required by the contractor to ensure uniformity. TMA PI designated four program integrity staff members for appointment to function as Alternate Contracting Officer Representatives (ACORs) to oversee implementation of the new antifraud requirements. ACORs are responsible for technical issues surrounding program integrity and in connection with administration of the contract. ACORs are also responsible for tracking a contractor's progress in compliance with Chapter 14, as well as performing on-site inspections, ongoing surveillance, and monitoring performance. Additionally, the appointment of a Senior Healthcare Fraud Specialist in charge of Contractor Compliance and Oversight enhances the potential for continuous improvement in fraud detection and intervention.

In 2001, ACORs continued to provide assistance and education to each managed care contractor, while performing contract oversight to ensure compliance with Chapter 14. Site visits enabled the

ACORs to establish rapport with the staffs of the contractors' program integrity offices and to observe hands-on utilization of the artificial intelligence software. Since implementation of the software, TMA has seen an increase in the number of fraud cases referred for review and further referral to the Defense Criminal Investigative Service.

The Program Integrity staff visited and trained Lead Agent staff from Regions 1, 2/5, 3/4, 6 and 7, and the Office of the Inspector General in Hampton, Virginia, as well as personnel at Johns Hopkins University Uniformed Services Family Health Plan.

The TMA Program Integrity Office publishes a monthly "Spotlight" report to provide ongoing education and guidance to the contractors' program integrity units.

In calendar year 1999, prior to TMA PI receiving the ACOR designations, there were only 11 fraud referrals from all of the contractors. In 2000, the referrals doubled. In 2001, all referrals began to be counted, not just the high dollar cases and the numbers soared to 110. The following tables detail the case referrals in 2000 and 2001.

Case Referrals for 2000

Contractors	Region	Total Referrals
Sierra	1	0
Anthem	2 & 5	2
Humana	3 & 4	6
Foundation	6	4
TriWest	Central 7 & 8	3
Foundation	9, 10 & 12	2
Foundation	11	0
UCCI	National	3
Humana	Overseas	2
Total Cases for 2000:		22

Case Referrals for 2001

Contractors	Region	Total Referrals
Sierra	1	4
Anthem Alliance	2 & 5	0
Humana Military (as of 6/01)	2 & 5	8
Humana	3 & 4	52
Health Net	6	11
TriWest	Central 7 & 8	5
Health Net	9, 10, & 12	9
Health Net	11	18
UCCI	National	1
Humana	Overseas	2
Total Cases for 2001:		110

Provider Sanctions

One of the functions of TMA PI is to track provider sanctions. Public Law 104-191 (Kennedy-Kassebaum), the Health Insurance Portability and Accountability Act (HIPAA) of 1996, enabled a new fraud and abuse data collection program for the reporting and disclosure of adverse actions against healthcare providers, suppliers, and practitioners. This data bank, the Health Integrity and Protection Data Bank (HIPDB), effective October 1, 1999, implements the law. As the federal Executive Agent, the Department of Health and Human Services (DHHS) is responsible for HIPDB and is now the sanction authority for all government agencies. An agreement between TMA Program Integrity and the DHHS enables sharing of information through provider taxpayer identification numbers so that TRICARE MCSCs may electronically identify sanctioned providers.

As part of the agreement, DHHS provides TMA PI with a monthly list of providers who have been excluded/terminated or suspended, and the ones who have been reinstated for the previous month. TMA PI reviews these lists and forwards the pertinent information with a cover letter to all MCSCs so that no payment is made to a sanctioned provider. DHHS sanctions are for a minimum of 5 years. For fiscal year 2000, there were 2,709 exclusions. That compares to 3,756 exclusions for FY 2001.

The Managed Care Support Contractor Operations Manual, Chapter 14, requires the MCSCs to report any adverse actions involving TRICARE providers to TMA PI. TMA PI is involved regularly with prosecutions and settlements involving TRICARE providers and timely reporting to both the DHHS Inspector General's office and the HIPDB.

TMA PI takes its own sanctioning action on quality of care cases or other cases in which there is no conviction. When there is an indication of possible patient harm, TRICARE's position is that it is better to suspend payments and claims than to put beneficiaries at risk. The project officer in TMA PI works with the TMA Office of General Counsel to sanction these providers.

References for sanctioned or reinstated providers are the 32 CFR199.9 Administrative Remedies for Fraud, Abuse, and Conflict of Interest and the Managed Care Support Contractor Operations Manual, Chapter 14.

TMA Program Integrity Activity Report, 1999-2001

The chart below shows the results of TMA PI's activities over the last three years. The launching of OPERATION TRICARE Fraud Watch in late 1999 with its increased emphasis on anti-fraud programs had an impact on the earlier identification of fraud, thus minimizing dollar losses within the program. The National Health Insurance Association of America has estimated that for every $1 spent on anti-fraud activities, $11 is saved.

DESCRIPTION	1999	2000	2001
Qui-Tams	256	181	141
Civil Cases Settled	92	138	61
DoD Hotlines	32	11	31
Written requests for consultation, case support, or assistance from DCIS, DOJ, and other law enforcement entities	584	600	532
Cases referred to DCIS	202	128	122

Cases referred to Military Criminal Investigative Offices	8	5	5
Balance Billing and Violations of Participation Agreement	57	29	42
Providers Sanctioned	2,976	2,709	3,756
TRICARE dollars identified for recovery (Fiscal year)	$2.9 million	$1.12 million	$11.2 million

Fiscal Stewardship

ClaimCheck

TRICARE ClaimCheck is a fully automated computer software program that contains specific auditing logic designed to ensure appropriate coding on professional claims and eliminate overpayments from these claims. The HBO and Company (HBOC) Clinical Information Services Department continually updates the ClaimCheck database and auditing guidelines with input from the Clinical Consulting Network. The Clinical Consulting Network represents a cross section of over 180 physicians with extensive clinical practice, academic work, or medical management experience. The ClaimCheck requirement started with the inception of each Managed Care Support Contract. ClaimCheck is monitored by the Operations Directorate and plays a key role in protecting government dollars.

The software is designed to detect and correct the billing practice known as unbundling, fragmenting, or code gaming. "Fragmenting,""unbundling," or "code gaming" involves separate reporting of the component parts of a procedure instead of reporting a single code which includes the entire comprehensive procedure. The practice is improper and is a misrepresentation of the services rendered. Providers are cautioned that such a practice can be considered fraudulent and abusive. Every TRICARE claim is run through this system of checks and balances. It is important to note that ClaimCheck does not set coverage/benefit policy; it merely audits claims for appropriate coding.

ClaimCheck has saved millions of dollars in erroneous payments each year since TRICARE required its use. During Fiscal Year 2001, ClaimCheck stopped $137,797,732 in fraudulent/abusive billings from being paid across all contracts. ClaimCheck continues to provide a substantial return on investment.

Special Duplicate Edit Software

This special duplicate edit software developed by TMA and used at each MCSC, has identified and accounted for $47,172,2000 for recoupment or offset nationally since 1997. This software is designed as a retrospective auditing tool.

For more information on the content of this report, please contact the TRICARE Management Activity Program Integrity Office in writing at the address below.

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